

The children of depressed parents have a persistently high risk of mental illness

Research question What is the long term outlook for people who have at least one parent with major depression?

Answer They have a high risk of mental illness that starts early and continues into early middle age

Why did the authors do the study? It's clear that depression is passed from generation to generation, but we don't know what happens to the children of depressed parents as they grow up and mature. These authors wanted to know the long term outlook for people who have at last one parent with a history of major depression.

What did they do? Twenty years ago, these authors recruited a group of 125 children, teenagers, and young adults with at least one depressed parent. The parents had moderate or severe major depression and were attending psychiatric outpatient clinics. The authors also recruited a similar group of 95 offspring without a depressed parent for comparison. The whole cohort was interviewed and assessed for mental and physical health problems at baseline, then 2 years, 10 years, and 20 years after recruitment. Assessments were done by researchers (who were unaware of each participant's history or their parent's history) using validated instruments such as the schedule for affective disorders and schizophrenia, the global assessment scale, and a checklist of medical illnesses.

The authors have already reported their findings at 10 years, when participants had a mean age of 25 years. Their current study reports findings from the 20 year follow-up, when participants had a mean age of 35 years. Of the original cohort of 220 participants, 151 were interviewed for this study.

What did they find? During the 20 years of the study, the offspring of depressed parents were three times more likely than controls to have major depression (65% *v* 27%, adjusted relative risk 3.3, 95% CI 2.0 to 5.7), and three times more likely to have an anxiety disorder (67% *v* 34%, 2.9, 1.6 to 5.1), mostly phobias. They were also more likely to have alcohol and drug dependence, although the difference was not statistically significant (19% *v* 8%, 2.7, 0.9 to 7.7).

The excess risk of depression started young and remained high throughout the 20 years of follow-up, with a peak age of onset between 15 and 20 years. By the end of the study, 83% of the 101 offspring of depressed parents had had a mental illness, and 65% had been depressed.

Offspring of depressed parents had more outpatient treatment for mental health problems than controls (37/101, 37% *v* 7/50; 14%, adjusted odds ratio 3.56; 95% CI 1.3 to 10). They also reported more physical illness, particularly cardiovascular disease and neuromuscular problems, and poorer social adjustment.

What does it mean? This study confirms poor mental health associated with having a depressed parent, and suggests that it starts early and continues at least into early middle age. The cohort was fairly small, however, so the findings on specific mental illnesses (such as substance misuse) weren't that robust. The offspring in this study had a parent with moderate or severe depression. The findings may not apply to the children of parents with milder illness who would be treated in primary care.

Weissman MM et al. Offspring of depressed parents: 20 years later. *Am J Psychiatry* 2006;163:1001-8

This summarises a paper that has been selected by bmjupdates. To register for bmjupdates (free email alerts about high quality new papers in your favourite subjects) go to <http://bmjupdates.com/>

Editor's choice

Whose research is it anyway?

Taking part in research has had a bad press. No wonder, given catastrophic reactions to new drugs that were being tested in London and Baltimore, the use of dead children's organs without their parents' consent in Liverpool, and drug trials in India done with inadequate consent. These are extreme examples that do not reflect the careful and respectful approach of most researchers. But even the best researchers struggle to strike a proper balance between the overall public good of their work and the need to respect and protect the privacy of research participants. So this week's *BMJ* carries the first of a series of articles debating confidentiality and consent in medical research.

The huge patient databases of the NHS provide unique opportunities for clinical and epidemiological analysis. But research involving patients or their personal data in the United Kingdom is now regulated by multiple sets of rules and laws that confuse researchers and inhibit and hamper studies. Add to this the problems of obtaining consent to reuse data for research when patients have died or moved on, and the challenges of ensuring confidentiality, and it's a wonder anyone still wants to do this kind of research.

One solution is to anonymise the data. But this is harder than it looks, argue Dipak Kalra and colleagues (p196) in the first article in the series. You can remove demographic details and discard the clinically rich narrative data in letters and reports. But patients may still be identifiable because of their unique clinical histories, and some will feel embarrassed or angered if they haven't explicitly consented to the use of their data. Record linkage has its pitfalls too: the genetic research databank in Iceland was declared unconstitutional for breaching privacy.

Asking for consent isn't easy, either. In the second part of the series next week Peter Singleton and Michael Wadsworth look closely at consent and true choice. One of the authors had to sign five forms to have one blood test taken when participating in a study. Faced with this or a 16 page consent form, say the authors, discretion may seem the better part of altruism and people may choose "not to choose." That's effectively opting out, a choice that Jenny Hewison and Andy Haines debate later in the series. And finally, in three week's time, Christina Davies and Rory Collins suggest how to wade through the necessary bureaucracy and make studies easier for both researchers and patients.

This is a series to cut out and keep (or the electronic equivalent) if you're a researcher. It's not ivory tower stuff. But one would-be surgical researcher may not be quite ready for even this kind of advice. Gwyn Samuel Williams is still struggling with finding something to publish, no matter how trivial, bearing his name (p 207). At each six month training review his reply to "so have you got anything published yet?" is still a glum "no." And that's despite seeing mirages of published studies on alcohol hand gel, patient care pathways, and hospital holy water.

Trish Groves deputy editor (tgroves@bmj.com)